1.0 Description of the Service

The Medicaid hospice benefit is a coordinated program of services that provides medical, supportive and palliative care to terminally ill recipients and their families/caregivers.

Program coverage complies with North Carolina Administrative Code 10A NCAC 13K, *North Carolina Rules Governing the Licensure of Hospice*, N.C. General Statute 10 G.S. 131E-201, and Federal Code of Regulations 42 CFR 418.

The services are provided according to a care plan established by an interdisciplinary team of medical professional and social support staff employed by or, under contract with the hospice agency, as allowed by the Centers for Medicare and Medicaid Services (CMS). Each care plan describes the method of providing services to meet the recipient's medical, psychosocial and spiritual needs. Services are provided in private homes, hospice residential care facilities, adult care homes, or in nursing facilities and hospitals when there is a contractual arrangement between the hospice and the facility. Hospice participation may limit Medicaid reimbursement of other services. The hospice benefit covers all care pertaining to the terminal illness.

1.1 Covered Services

1.1.1 Physician Services

Physician services are provided by a doctor of medicine or doctor of osteopathy licensed by the North Carolina Board of Medicine. The services are administrative or supervisory and include participating on the interdisciplinary team, assisting with the development of and approving care plans, and serving as a consultant to the hospice staff.

1.1.2 Nursing Services

Nursing services are provided by a registered nurse (RN) or licensed practical nurse (LPN) licensed by the North Carolina Board of Nursing and in accordance with the G.S. 90-171.19-.47, *North Carolina Nursing Practice Act*, 21 NCAC 36, current standards of practice, and agency policy.

1.1.3 Medical Social Services

Services include a range of supportive services provided by a qualified social worker as defined in 10A NCAC 13K and 42 CFR 418.

1.1.4 Counseling Services

Counseling services are provided for the recipient, family members, and others caring for the recipient. The service includes such activities as supportive and dietary counseling for the recipient, counseling to help the recipient and informal caregivers adjust to the recipient's approaching death, and training for unpaid caregivers. Bereavement counseling is available to family and caregivers after the recipient's death.

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1.1.5 Pastoral Care Services

Each hospice agency designates a clergy member to be responsible for coordinating the recipient's and his/her family's spiritual care. The clergy member is an individual who has received a degree from a school of theology and has fulfilled appropriate denominational seminary requirements, or an individual who, by ordination or authorization from the recipient's denomination, has been approved to function in a pastoral capacity.

1.1.6 Home Health Aide and Homemaker Services

Home health aides perform the personal care tasks included in the plan of care and in accordance with 21 NCAC 36. The aide can also perform household services that assist in maintaining a safe and sanitary environment in areas of the home used by the recipient.

Homemaker services include assistance with personal care, maintenance of a safe and healthy environment, and other support services as outlined by the recipient's plan of care.

1.1.7 Medical Appliances and Supplies

Appliances include durable medical equipment (DME) as well as other self-help and personal comfort items related to the palliation or management of the recipient's terminal illness. Equipment is provided for home use while the recipient is receiving hospice services.

1.1.8 Drugs and Biologicals

Drugs and biologicals are those used for pain relief and symptom control related to the terminal illness.

1.1.9 Therapy Services

Covered therapy services include occupational and physical therapy, speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

1.1.10 Short-Term Inpatient Care

Inpatient care (general and respite) is provided in a hospice inpatient unit, a hospital, or nursing facility under a contractual arrangement with the hospice agency. An inpatient stay (general) is of a short duration for either the management of symptoms or for palliative care that cannot be provided in any other setting. An inpatient stay (respite) provides short term relief for the caregiver.

1.1.11 Ambulance Services

Transport must be related to the palliation or management of the recipient's terminal illness.

1.1.12 Nursing Facility Room and Board

Medicaid reimburses the hospice for the nursing facility room and board charge when a resident elects the hospice benefit or a Medicaid hospice recipient becomes a resident of the facility.

1.2 Levels of Care

Each day of the recipient's hospice coverage is classified at one of four levels of care. The Medicaid reimbursement for the service is made at a per diem rate based on the level of care and the location of the recipient.

1.2.1 Routine Home Care

Routine home care is the basic level of care provided to support a recipient. It is provided in a private residence, a hospice residential care facility, or an adult care home. It also may be provided in a nursing facility if the facility has a contractual arrangement with the hospice agency.

1.2.2 Continuous Home Care

Continuous home care is provided during a medical crisis as needed to keep the recipient at home and when the recipient's physician believes that he/she needs continuous care, primarily nursing care, to achieve palliation or management of acute medical symptoms. The recipient must need care for at least eight hours of the calendar day. The hours may be split into two or more periods during the day. Nursing services by a RN or LPN must be provided for at least half of the hours of care in a day. Homemaker and home health aide services may be used to supplement the nursing care for the remaining hours.

1.2.3 Inpatient Respite Care

Inpatient respite care is short-term care to relieve family members and other unpaid caregivers who care for a recipient in a private residence. Respite may be provided only on an occasional basis for up to five consecutive days for each occurrence, as defined by agency policy and based on the needs of the primary caregiver. It is provided in a hospice inpatient facility, a hospital, or nursing facility under arrangement with the hospice agency. The hospital or nursing facility must meet the special hospice standards for staffing and patient care areas as specified in 10A NCAC 13K and 42 CFR 418. For a detailed explanation on determining annual limitations as it relates to inpatient care, refer to 42 CFR 418.

1.2.4 General Inpatient Care

General inpatient care is for the management of symptoms or to perform procedures for pain control that cannot be performed in other settings. The care is provided in a hospice inpatient facility, a hospital, or a nursing facility under arrangement with the hospice agency. The hospital or nursing facility shall be in compliance with the special hospice standards for staffing and patient care areas as specified in 10A NCAC 13K and 42 CFR 418. For a detailed explanation on determining annual limitations on payments to inpatient care, refer to 42 CFR 418.

Note: All rules, regulations, and statutes cited in this clinical coverage policy are adopted by reference.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Recipients with Medicaid for Pregnant Women Coverage (MPW)

Recipients with Medicaid for Pregnant Women (pink Medicaid identification card) are eligible for hospice services if the terminal illness is pregnancy-related. Refer to **Section 5.8.2** for information regarding prior approval for MPW recipients.

2.3 Medicare Qualified Beneficiaries (MQB)

Coverage for Medicare Qualified Beneficiaries (buff Medicare Aid identification card) is limited to coinsurance on drugs and biologicals when applicable.

2.4 Medicare/Medicaid Dual Eligibility

Dually eligible recipients are eligible for hospice services. Medicaid and Medicare hospice must be elected simultaneously, and Medicare is the primary payer.

2.5 Ineligible or Deductible Status

When a recipient receiving hospice services becomes ineligible for Medicaid or goes into a deductible status, the following apply:

1. If the recipient remained on hospice throughout the ineligible period and, if applicable, the hospice charges were applied to the deductible, there is no change in the benefit period status.
2. If the recipient discontinues hospice coverage when becoming ineligible for Medicaid, the situation is handled like a revocation. The recipient forfeits any remaining days in the current benefit period and enters the next benefit period if re-electing hospice after Medicaid eligibility is restored.

2.6 Special Provisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition identified through a screening examination. While there is no requirement that the service, product or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount or frequency described in this coverage policy do not apply if the product, service or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at http://www.dhhs.state.nc.us/dma/prov.htm.

3.0 When the Service is Covered

3.1 General Criteria

Medicaid covers hospice services when all the conditions specified in this Section and **Section 3.2** are met.

1. The service is medically necessary as determined by Medicaid policies and prescribed by the physician.
2. The service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the recipient's needs.
3. The level of service can be safely furnished and for which no equally effective and more conservative or less costly treatment is available statewide.
4. The service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Medical Necessity Criteria

Medicaid covers hospice services when the recipient has a life expectancy of six months, or less if the disease follows its expected course, that is supported by the physician's written certification of the recipient's terminal prognosis.

4.0 When the Service is Not Covered

Hospice services are not covered when:

1. The recipient does not meet the eligibility criteria **in Section 2.0**.
2. The recipient does not meet the criteria specified in **Section 3.0.**
3. The provider does not comply with all Medicaid requirements as specified in this policy.
4. The service duplicates another provider's procedure.
5. The service is experimental, investigational or part of a clinical trial.

5.0 Requirements for and Limitations on Coverage

5.1 Referrals

The hospice agency may accept referrals from any source. Should the attending physician not be the referral source, he/she must be contacted to authorize hospice care and to affirm that the recipient has a life expectancy of six months or less, if the disease process runs its expected course.

5.2 Physician Direction

The recipient's physician must agree to direct hospice services in accordance with all applicable requirements.

5.3 Physician Certification

The hospice agency must obtain written physician certification of the recipient's terminal prognosis. This signed statement must indicate that, based on the physician's clinical judgment regarding the normal course of the individual's illness, the recipient has a life expectancy of six months or less if the disease follows its expected course. A copy of the signed statement must be on file in the recipient's medical record.

5.3.1 Certification for Initial Benefit Period

The initial written certification statement must be obtained from the physician no later than two calendar days after hospice election. It must be signed by either the medical director of the hospice or the physician member of the hospice interdisciplinary team and the recipient's attending physician (if he/she has an attending physician). Verbal certification may be used if the written certification cannot be obtained within the two day time frame. If verbal certification is obtained, written certification must be in the recipient's medical record prior to submitting a claim.

5.3.2 Certification for Additional Benefit Periods

A new physician certification of terminal illness is required at the beginning of each benefit period no later than two calendar days after the beginning of the period. Recertification shall be signed by the hospice medical director, physician member of the interdisciplinary team or the recipient's attending physician.

5.4 Assessment

An assessment visit shall be made to the recipient's place of residence by a member of the hospice interdisciplinary team after consulting with the attending physician. The visit is made to determine the appropriateness of hospice services and to gather the information needed to develop a care plan. The agency shall determine if it can provide the services needed prior to accepting the recipient as a hospice client.

5.5 Electing the Hospice Benefit

Before providing services, the recipient or the recipient's representative must confirm the choice of hospice election by signing a hospice election statement.

5.5.1 Medicare Hospice Benefit

Recipients who are dually eligible for Medicaid and Medicare and elect the Medicaid hospice benefit must also elect the Medicare hospice benefit.

5.5.2 Election Statement

The election statement form is developed by the hospice providing the service. The statement may be combined with the Medicare election statement or on a separate form. The election statement is effective from the initial benefit period through all the subsequent benefit periods as long as the recipient does not revoke the election, change hospice agencies, or is not discharged from hospice care. The election form shall include:

1. declaration of the recipient's intent to receive Medicaid hospice coverage;
2. the name of the hospice agency that shall provide the care;
3. a statement acknowledging that the recipient has been informed of the palliative rather than the curative nature of hospice care as it relates to the terminal illness;

4. a listing of the Medicaid services that shall be waived when electing the hospice benefit; and
5. the effective date of the election period.

5.5.3 Waiver of Rights to Other Medicaid Covered Services

When a Medicaid recipient elects hospice services, the recipient waives his/her rights to Medicaid coverage of certain other services that replicate the services covered under the hospice benefit as specified below.

1. Medicaid coverage for home health, DME, and home infusion therapy (HIT) services is not allowed for hospice recipients when the service pertains to the treatment of the terminal illness or related conditions.
2. Medicaid coverage for private duty nursing (PDN) and personal care services (PCS and PCS-Plus) is not available for recipients electing hospice services.
3. Drugs and biologicals pertaining to the terminal diagnosis are reimbursed to the hospice as part of the hospice per diem. Medicaid will make direct reimbursement to the pharmacy for any drugs used to treat illnesses or conditions not related to the terminal illness.

5.6 Provision of Service

Hospice services are covered when provided in the following locations:

1. the recipient's private residence,
2. an adult care home (considered the recipient's residence),
3. a hospice residential care facility or hospice inpatient unit, or
4. a hospital or nursing facility or Intermediate Care Facility for the Mentally Retarded (ICF-MR) under a contractual arrangement with the hospice agency.

Note: A nursing facility or ICF-MR recipient must be approved for nursing facility or ICF-MR level of care, by Medicaid's fiscal agent.

5.7 Benefit Period

Hospice coverage is divided into "benefit periods" for both Medicare and Medicaid. The initial hospice election statement remains valid through all the benefit periods as long as there is no break in coverage.

5.7.1 Length of Benefit Period

The benefit periods are available in an initial 90-day period, a second 90-day period, and an unlimited number of 60-day periods.

5.7.2 Coordinating Medicaid and Medicare Benefit Periods

Medicaid and Medicare benefit periods are identical and run concurrently. When the recipient is dually eligible, the benefit periods for both programs must be coordinated as follows:

1. **Recipient has not previously received Medicare hospice:** Elections must be made simultaneously for both programs**.**
2. **Recipient is currently receiving Medicare hospice:** Medicaid hospice will begin on the same day in the benefit period as Medicare hospice. For example, if a recipient is at day 45 of the first benefit period for Medicare, Medicaid coverage begins on day 45 of the first benefit period.

3. **Recipient has received but is not currently receiving Medicare hospice:** The recipient resumes Medicare at the next available benefit period and begins Medicaid coverage at that same period. For example, if the second period is the next available Medicare period, the recipient begins Medicaid coverage at the beginning of the second period.

5.8 Reporting Hospice Participation

The hospice agency shall report initial hospice participation to Medicaid's fiscal agent's prior approval unit when a recipient elects Medicaid hospice benefits. Hospice claims will not be reimbursed without this notification.

The report must be made:

1. initially, within six calendar days of the election of the Medicaid hospice benefit;
2. at the beginning of each benefit period;
3. if the recipient is dually eligible under Medicare/Medicaid and is a nursing facility resident and the agency is billing Medicaid for room and board charges;
4. if the recipient transfers to another hospice agency; or
5. if the recipient is discharged from or revokes hospice.

Note: It is not necessary to report the recipient's death.

Refer to **Attachment B** for specific information regarding the initial and continuing hospice participation reporting processes and requirements.

Note: Reporting a transfer of hospice care from one agency to another shall be coordinated to prevent duplication of dates of service, resulting in the denial of Medicaid payment.

5.9 Prior Approval

5.9.1 Prior Approval for Regular Medicaid Recipients

Prior approval is not required when the recipient has regular Medicaid coverage (blue MID card).

5.9.2 Prior Approval for MPW Recipients

Prior approval is a requirement for coverage when the recipient has MPW coverage. Prior approval for MPW recipients is requested by the recipient's attending physician as follows:

1. Requests must be submitted in writing using the general Request for Prior Approval form (372-118).
2. The physician must provide information detailing the complications of the pregnancy, medical necessity for hospice services, the potential impact if the service is not provided, the frequency of visits, and the anticipated duration of services.
3. The hospice agency enters the agency name and provider number in block #16 of the form.
4. The physician signs and dates the form in blocks #14 and #15.
5. The completed form is mailed to Medicaid's fiscal agent.
6. Forms can be obtained from Medicaid's fiscal agent.

5.10 Hospice Revocations and Discharges from Hospice Resulting in Termination of Hospice Coverage

5.10.1 Revocations

A recipient may revoke his/her hospice election at any time by completing a signed revocation statement. Medicare/Medicaid recipients must simultaneously revoke hospice coverage for both programs. The statement must indicate that the recipient revokes the hospice election and the effective date of the revocation. The effective date cannot be earlier than the date the recipient signs the revocation statement.

By revoking Medicaid hospice coverage, a recipient:

1. forfeits any remaining days of coverage in the current benefit period after the revocation date, and
2. is eligible to resume coverage of the waived Medicaid benefits effective on the date of revocation.

5.10.2 Discharges

The hospice agency may discharge a recipient in accordance with applicable law, rules and regulations, and agency policy. The agency must promptly report the recipient's revocation or discharge to Medicaid's fiscal agent because hospice participation information may affect Medicaid payment for other services. The agency may bill for the date of discharge or revocation.

5.10.3 Re-Electing Hospice after Revocation

If a recipient wishes to resume hospice, he/she or the representative re-elects hospice for the next benefit period. The recipient is considered to be a new hospice client. A new election statement, plan of care (POC), and physician certification are required. Additionally, a participation report to Medicaid's fiscal agent is required, as described in **Section 5.8**.

6.0 Providers Eligible to Bill for the Service

To qualify for enrollment as a Medicaid hospice provider, the agency must be Medicare-certified to provide hospice services within North Carolina and be licensed to provide hospice services by the DFS as defined in 10 G.S.131E-201 (3).

7.0 Additional Requirements

7.1 Coordinating Care

The hospice provider is responsible for assessing and coordinating existing home care services being rendered to a recipient electing the hospice benefit. Additionally, the provision of care unrelated to the terminal illness must be coordinated to avoid duplication of services.

The hospice agency shall notify the other service providers of the recipient's request for hospice services prior to admitting the recipient for hospice care. This policy also pertains to Medicare covered hospice benefits for dually eligible recipients.

7.1.1 Community Alternatives Program (CAP)

If the recipient participates in a CAP program, the CAP case manager shall be contacted. CAP recipients have a cost limit for Medicaid home and community based services that may impact their ability to receive hospice services.

Note: CAP participants have a two-letter code in the CAP block of the Medicaid identification (MID) card.

7.1.2 Providing Care to Nursing Facility Residents

Hospice services may be provided to a nursing facility resident if a contractual agreement has been made between the hospice agency and the facility. The contract must specify that the hospice agency is responsible for the professional management of the recipient's care and that the facility agrees to provide room and board. All requirements and services outlined in the N.C. Medicaid Nursing Facility Provider Manual (on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm) are included in the provision of room and board. Medicaid reimbursement for room and board costs is made to the hospice. The agreement between the hospice and the nursing facility shall specify payment arrangements and shall comply with the current North Carolina Rules Governing the Licensure of Hospices. Hospice is responsible for medications and DME directly related to the terminal illness with the exclusion of those outlined in the reference above. All other details related to the provision of care are included in the agreement.

7.1.2.1 Dually Eligible Nursing Facility Residents

If a recipient is dually eligible for Medicare and Medicaid, hospice must be elected simultaneously. Medicare is the primary payer. Medicaid will reimburse the hospice for nursing facility room and board charges. Additionally, Medicaid will reimburse for coinsurance on hospice covered drugs and respite days, when applicable. Hospice participation must be reported to Medicaid's fiscal agent if the recipient is dually eligible under Medicare/Medicaid and if the agency is to bill Medicaid for the nursing facility room and board charges. All reporting requirements must be followed.

7.1.2.2 Patient (Recipient) Monthly Liability

The hospice agency assumes responsibility for collecting the patient monthly liability (PML). The agency notifies the local department of social services (DSS) of the recipient's election of hospice, and DSS forwards to the hospice agency notification of the PML amount on the Notification of Eligibility for Medicaid/Amount and Effective Date of Patient's Liability Form (DMA-5016). The nursing facility can act as the hospice agent in collecting the PML, if included in the contractual agreement.

7.1.2.3 Prior Approval for Level of Care

Hospice is responsible for ensuring that the prior approval process has been completed and that the recipient is approved for nursing facility level of care. This process can be completed by the hospice or through arrangement with the nursing facility, hospital discharge planner, physician, or other sources. Hospice recipients in nursing facilities must meet the same level of care requirements as other Medicaid nursing facility recipients. The recipient must occupy a Medicare/Medicaid certified bed. The hospice agency should retain a copy of the FL-2 in the recipient's records on site at the hospice agency.

7.1.3 Providing Care in an Adult Care Home

Hospice services can be provided for Medicaid recipient in an adult care home (ACH) when the recipient elects the hospice benefit. The ACH is considered the recipient's place of residence and the basic care is provided by the ACH staff. The hospice has the responsibility for the professional management of the recipient's care.

The plan of care must include the services provided by both the ACH and hospice (i.e., room and board, ACH-Personal Care Services). The hospice agency is responsible for coordinating all services included in the plan of care. A copy of the hospice plan of care will be provided to the ACH.

7.1.4 Pharmacy Services

Drugs and biologicals pertaining to the terminal diagnosis are reimbursed to the hospice as part of the hospice per diem. Medicaid will make direct reimbursement to the pharmacy for any drugs used to treat illnesses or conditions not related to the terminal illness. The hospice provider must supply the diagnosis and ICD-9-CM code for the terminal illness when contacted by the pharmacy. The pharmacy must have this information in order to process the claim.

Refer to Clinical Coverage Policy #9, *Outpatient Pharmacy Program*, on DMA's website at http://www.dhhs.state.nc.us/dma/mp/mpindex.htm for additional information.

7.2 Delivering and Supervising Care

Delivery and supervision of the delivery of care shall conform to all applicable laws, rules and regulations, the current standard of practice, and agency policy. Services must be provided as specified in the plan of care developed and approved by the interdisciplinary team. Core hospice services (nursing services and medical social service and counseling) shall routinely be provided directly by hospice employees. Other covered services shall be provided by agency employees or under contractual arrangements. Contractual agreements shall be in writing and in compliance with 10A NCAC 13K and 42 CFR 418.

7.3 Monitoring Care

Members of the hospice interdisciplinary team monitor the recipient's condition and initiate changes in the plan of care (POC) as needed. The recipient's attending physician also participates in this process. The review and resulting updates to the POC must be completed every two weeks to ensure that the recipient's needs are met. Each review shall be documented in the recipient's record.

7.4 Changing Agencies

A recipient may change hospice agencies between benefit periods and once during each benefit period. An agency change is not a revocation of hospice. When a change occurs during a benefit period, the patient completes the period with the new agency.

To change agencies during a benefit period, the recipient gives a signed statement to both the current agency and the new agency. The statement indicates the recipient's intent to change agencies, provides the name of the current agency, states the name of the new agency, and identifies the effective date of the change.

The transfer is coordinated with the attending physician and any other care providers to ensure continuity of services. The current or first agency must cease billing for services on the day prior to the effective date on the notice. The new agency assumes responsibility for the recipient's care on the effective date of the change and bills for that date of service. The existing plan of care can be used or the new agency may develop a new one.

The first agency must report the transfer of the recipient to Medicaid's fiscal agent. Payment to the new agency depends on a report of the termination of services by the first agency. The new agency must contact Medicaid's fiscal agent to report the admission of the recipient to hospice services under the new agency. The transfer must be reported to Medicaid's fiscal agent no later than the sixth day after the date of transfer (day of report plus six previous days).

7.5 Electronic Signatures

N.C. Home Care Licensure Rules provide requirements for accepting electronic signatures for documentation.

8.0 Policy Implementation/Revision Information

Original Effective Date: August 1, 1984

Revision Information:

Date	Section Updated	Change

Attachment A: Claims Related Information

A. General Guidelines

1. Reimbursement requires compliance with all Medicaid requirements.
2 Direct care that is provided by the recipient's attending physician or a consulting physician is billed directly to Medicaid.
3. An additional charge for room and board may be billed to Medicaid if the recipient is dually eligible under Medicare and Medicaid and is a nursing facility resident. The agency bills routine home care or continuous home care, whichever is applicable, in addition to the room and board charge when Medicaid is the primary payor. When the recipient also has Medicare, the applicable hospice rate is billed to Medicare and the nursing facility room and board charge is billed to Medicaid. Medicare does not cover nursing facility room and board charges. The charge can be billed to Medicaid, if requirements are met.
4. The hospice must bill Medicaid for the room and board and reimburse the nursing facility. Claims filed directly from the nursing facility will be denied once a recipient elects hospice.

B. Claim Type

Hospice providers bill services on the UB-92 claim form.

The Value Code 61 and the five-digit code for the applicable Core Based Statistical Area (CBSA) rate are indicated in Form Locator 40 on the UB-92 claim form.

C. Diagnosis Codes that Support Medical Necessity

Providers must bill the appropriate ICD-9-CM diagnosis code that supports medical necessity. Diagnostic codes must be billed at their highest level of specificity.

D. Revenue Codes and Services Billed

Hospice services are provided and billed according to level of care and the location of the recipient for each day of the benefit period. Level of care is classified as one of four types based on the intensity of service that the recipient requires on that day. Information regarding revenue codes appears on the following pages.

Revenue Code	Unit of Service	Description
651 Routine Home Care	1 Day	**Routine Home Care** is the basic level of care that is provided to support the recipient. It may be provided in a private residence, a hospice residential care facility or an adult care home. It may also be provided in a nursing facility if the facility has a contractual arrangement with the hospice agency. It is billed by the day and is the agency's basic per diem rate. This service code is limited to once per day per recipient, same or different provider. **Routine Home Care/Continuous Home Care/Inpatient Respite Care/General Inpatient Care** is not allowed on the same day. The agency should provide and bill the appropriate level of service.

Revenue Codes and Services Billed, continued

Revenue Code	Unit of Service	Description
652 Continuous Home Care	1 Hour	**Continuous Home Care** is provided during a medical crisis and is billed by the hour. This level of service is provided when the recipient's physician feels that continuous care, primarily nursing care, is needed. The care is given to achieve palliation or management of acute medical symptoms. It can be provided in the private residence, hospice residential care facility, adult care home, or nursing facility. The recipient must need: • Continuous care for at least eight hours of the calendar day (the hours may be split) • Nursing services by a RN or a LPN for at least half of the hours of care in a day • Homemaker and home health aide services to supplement the nursing care • **Continuous Home Care** limited to a maximum of 24 units per day **Continuous Home Care** is not allowed on the same day as **Routine Home Care/Inpatient Respite Care/General Inpatient Care**. The agency should provide and bill the appropriate level of service.
655 Inpatient Respite Care	1 Day	**Inpatient Respite Care** is short-term care to relieve family members or other unpaid caregivers providing care for the recipient in the private residence. • It is provided in a hospice inpatient facility or in a hospital or nursing facility under a contractual arrangement. • Hospitals or nursing facilities must meet the special hospice standards for staffing and recipient areas. • This service can only be provided on an occasional basis for up to five consecutive days at a time. If the recipient remains in the facility longer than five days, the extra days are billed at the routine home care rate. • The date of discharge is usually billed at the routine home care rate. • The inpatient respite rate may be billed if the discharge is due to the recipient's death. **Inpatient Respite Care** counts toward the annual limit on inpatient care. This service code is limited to once per day per recipient, same or different provider. **Inpatient Respite Care** is not allowed on the same day as **Routine Home Care/Continuous Home Care/General Inpatient Care**. The agency should provide and bill the appropriate level of service.

Revenue Codes and Services Billed, continued

Revenue Code	Unit of Service	Description
656 General Inpatient Care	1 Day	**General Inpatient Care** is defined as the reimbursement made to the hospice for a recipient in an acute care hospital.. The service is billed by the day as follows: • The number of days that a recipient receives general inpatient care is billed, beginning with the date of admission. • The date of discharge is billed at the appropriate rate. If discharge is delayed while a recipient awaits nursing facility placement, the general inpatient rate can be billed for up to three days. Bill any subsequent days as if the recipient is in a nursing facility; that is, the routine home care rate plus the appropriate long term care rate to cover room and board. If a patient is discharged as deceased, bill the general inpatient rate for the date of discharge If the recipient is hospitalized for a condition not related to the terminal illness, the hospital is paid for the recipient's inpatient care. Additionally, the hospice bills the routine home care rate during the inpatient stay. **General Inpatient Care** counts toward the annual limit on inpatient care. This service code is limited to once per day per recipient, same or different provider**.** **General Inpatient Care** is not allowed on the same day as **Routine Home Care/Continuous Home Care/Inpatient Respite Care/General Inpatient Care:** The agency should provide and bill the appropriate level of service.
659 Hospice Nursing Facility Room and Board	1 Day	**Hospice Nursing Facility Room and Board** is the charge billed by the hospice agency for a recipient residing in a nursing facility. It is billed in addition to routine home care or continuous home care as applicable. The hospice agency reimburses the nursing facility under a contractual arrangement. The rate of reimbursement is based on 95 percent of the per diem for the individual nursing facility. The amount is reduced by the amount of the PML when applicable.

E. Reimbursement Rate

1. Medicaid payment rates for hospice services must be equivalent to Medicare hospice rates, and Medicare methodology must be followed. The hospice reimbursement for nursing facility room and board must equal to at least 95 percent of the nursing facility rate.
2. The reimbursement rate for routine care and continuous home care is dependent on the recipient's location by Core Based Statistical Areas (CBSA) on the date of service. The maximum allowable rates for the hospice services are determined by the location of the hospice agency.

Attachment B: Hospice Participation Reporting

Steps for Hospice Participation Reporting

Step 1: Telephone contact is made with Medicaid's fiscal agent's prior approval unit no later than six days following of the election of hospice. The report must be made initially and at the beginning of each benefit period.

Step 2: The following information must be provided:

- the recipient's name and MID number as it appears on the MID card,
- the benefit period start and end dates,
- the ICD-9-CM code for the primary diagnosis related to the terminal illness,
- the agency's Medicaid provider number and name as it appears on the Medicaid provider agreement, and
- the name and contact number of the person making the report.

Medicaid's fiscal agent assigns a system-generated confirmation number that is unique to the recipient and the hospice agency. It is effective through the last day of the benefit period, unless the recipient revokes hospice, is discharged or transfers to another agency before that date. The confirmation number and the date of the telephone call should be recorded in the recipient's record as the agency's proof of the contact for reporting. The confirmation number with applicable approval dates and agency provider number are documented in the MMIS system. The information is not entered on the hospice claim when billed.

The provider **must** notify Medicaid's fiscal agent if the recipient revokes hospice, is discharged or transfers to another agency.

When the recipient has Medicare and Medicaid, participation should not be reported unless Medicaid is going to be billed. Medicare is the primary payer when there is dual coverage and there should be no hospice charges to bill to Medicaid unless the recipient is in a nursing facility.

Report Hospice Participation When Medicaid Is Pending

When the recipient has made application for Medicaid but it is still pending approval, the hospice participation must be reported. Medicaid pending reporting enables the provider to receive Medicaid reimbursement for services retroactive to the election date.

When a recipient elects hospice with pending Medicaid (i.e., has made an application for Medicaid) but has not received approval, the hospice agency must make two telephone calls for reporting.

- The initial telephone call is made within the six days of the recipient's election of hospice. Inform Medicaid's fiscal agent that the recipient's Medicaid is pending. Medicaid's fiscal agent will document the telephone call for later reference.
- A second telephone call must be made when the recipient's pending Medicaid is approved. The hospice agency should let Medicaid's fiscal agent know that this recipient was reported previously as a pending Medicaid recipient. Medicaid's fiscal agent will assign and document a confirmation number with dates retroactive to cover services to the date of the original telephone call.

Attachment C: Providing Medicaid Hospice Services

The information below details the basic steps to receive Medicaid hospice coverage for a hospice recipient.

Step 1: Receive the Referral

Hospice referrals may come from multiple sources, including but not limited to, the attending physician, a member of the family or a friend, hospital discharge planners, or social workers. When the referral is made by sources other than the physician, the recipient's attending physician must be contacted to confirm the medical prognosis.

Step 2: Assess Appropriateness

A member of the hospice interdisciplinary team visits the recipient to assess appropriateness of hospice services after consulting with his/her physician. The agency also needs to determine if it can provide the services needed. There should be a resolution to any questions or concerns about the recipient's care before proceeding. The attending physician, family members, or others are contacted as appropriate.

Step 3: Verify Medicaid Eligibility

The recipient's Medicaid eligibility must be established as well as the information on the card (i.e., eligibility dates, insurance information, and other important indicators) validated.

Blue: A recipient may be considered for hospice.

Pink: Covers only pregnancy-related services. The need for hospice services must be related to the pregnancy and must be prior approved to be covered.

Buff: A recipient is not eligible for hospice as a Medicaid service. Medicaid will only reimburse for any applicable Medicare co-insurance and deductibles.

Step 4: Obtain Medicaid Election Statement

Before providing services, the recipient or his/her representative must sign a hospice agreement in accordance with the requirements of this policy. The Medicaid statement may be on a separate form, combined with the Medicare election statement or may be part of the agency's election form. Review section 5.3 of this policy for requirements related to the election statement.

Step 5: Obtain Physician Certification of Terminal Illness

The physician's certification of the terminal nature of the recipient's illness must be obtained no later than two calendar days after the effective date of the election period. The certification may be verbal or written. If the certification is verbal, the agency must have the physician's written certification of the terminal illness in the record prior to submitting a claim for Medicaid payment.

Step 6: Report Hospice Participation

Contact the prior approval unit at Medicaid's fiscal agent to report hospice participation in accordance with the requirements of this policy. The recipient's election of hospice must be reported no later than the sixth day after the start of the benefit period (day of report plus six previous days). A report is made initially and when a recipient begins a new benefit period, revokes hospice, is discharged, or transfers to another hospice agency. It is not necessary to make a contact to report the recipient's death. Information in the eligibility system will document the recipient's death in the Medicaid system. Refer to **Attachment B** for requirements on reporting hospice participation.

Step 7: Develop the Plan of Care (POC)

Prior to the start of care, the hospice interdisciplinary team must develop a plan of care (POC) to meet the recipient's needs. The plan must be in compliance with the current North Carolina Rules Governing the Licensure of Hospices, 10A NCAC 13, 42 CFR 418, and agency policy. One of the team members developing the POC must be a physician or registered nurse. The POC must be developed as specified in the current CMS Medicare Benefit Policy Manual.